NOTICE OF TRANSFER OR DISCHARGE

(Resident's Name) (Date)

(Nursing facility name) (Family member/legal representative)

(Nursing facility address) (Address)

You are being provided this notice to inform you that, for the reasons explained below, you will be transferred or discharged from this facility.

YOU WILL BE TRANSFERRED/DISCHARGED FOR THE FOLLOWING REASONS:

A listing of the permitted reasons for transfer and discharge is found at federal regulation 42 CFR 483.12 (a)(2).

TRANSFER/DISCHARGE LOCATION: (mark and complete one of the following)

_____ **You will be** _____ **to the following location** _____
(transferred/discharged)

(placement location/facility)

on _____ **.**
(Effective date of transfer/discharge)

OR,

_____ **The location to which you will be transferred or discharged is unknown at the time of this notice. This nursing facility will take the following steps to ensure a safe and orderly transfer or discharge from the facility.**

_____ **Bed hold information has been provided to the resident regarding transfer/discharge.**

BY: _____ **TITLE:** _____
(Facility Representative Signature)

ADVOCATES/ ASSISTANCE:

For assistance in understanding your rights or filing an appeal, you may contact the state long term care ombudsman. The ombudsman's name and address is KELLY MOORSE, MONTANA LONG TERM CARE OMBUDSMAN, 111 SANDERS STREET, PO BOX 4210, HELENA, MONTANA 59604-4210. THE OMBUDSMAN'S TELEPHONE NUMBER IS 1-800-332-2272.

For assistance in understanding and asserting your rights, if you are developmentally disabled or mentally ill you may contact the Montana Advocacy Program. The Montana Advocacy Program's address is PO BOX 1681, 400 N PARK AVENUE, 2nd floor, HELENA, MT 59624-1681. THE MONTANA ADVOCACY OFFICE'S TELEPHONE NUMBER IS 1-800-245-4743 or (406) 449-2344.

FAIR HEARING RIGHTS:

If you disagree with the facility's decision to transfer or discharge you, YOU MAY REQUEST A HEARING WITHIN 30 DAYS of the date of this letter. A hearing may be requested for you, by a family member, a friend, legal counsel, an advocate, or other representative of your choice. Your request must be mailed or delivered to:

Office of Fair Hearings
Department of Public Health and Human Services
PO Box 202953
2401 Colonial Drive, 3rd Floor
Helena, Montana 59620-2953

Upon receipt of your timely request, a hearings officer will be appointed by the Department of Public Health and Human Services to hear your case and issue a decision. You will be contacted by the hearing officer regarding scheduling of a hearing. You have the right to represent yourself at the hearing or to use legal counsel, an advocate, a relative, a friend or another person to represent you.

The facility's decision to transfer or discharge you does not affect your Medicaid eligibility. If you have any questions regarding Medicaid coverage of services in the setting to which the facility proposes to transfer or discharge you, please contact your local county office of human services or the department's Senior and Long Term Care Division at (406) 444-4077.

REQUEST FOR A FAIR HEARING:

If you would like to request a fair hearing you may fill out the information below and mail it to the above address.

TO: Fair Hearings Officer: I would like to request a Fair Hearing to appeal the decision to transfer/discharge me from a nursing facility.

_____ _____
(Nursing Facility Name) **(Resident's Name)**

_____
(Requestor's name [if different than resident's] please print)

_____ _____
(Requestor's Signature) **(Date of Request)**

_____ _____
(Requestor's Address) **(Telephone Number)**